



MONTANA DPHHS OUTPATIENT HOSPITAL PAYMENT PROJECT

Technical Specifications

Note: This document describes the current technical specifications of the new hospital outpatient payment method being designed by ACS State Healthcare LLC under contract to the Department of Public Health and Human Services. It has been made available for the information of hospitals and other interested parties.

I. Overview

Implementation date. All claims with date of service on or after August 1, 2003.

Reasons for the change. Since 1994 DPHHS has paid for outpatient hospital services using a blended approach based on Day Procedure Groups, which themselves are based on the ICD-9-CM procedure codes that are shown at the header level of UB-92 bills. The Department is moving to a new payment method for five reasons.

- **ICD-9-CM procedure codes no longer available.** Under the Health Insurance Portability and Accountability Act, payers such as DPHHS cannot require hospitals to include ICD-9-CM procedure codes on outpatient bills as of October 16, 2003.
- **DPGs no longer supported.** The developers of DPGs will no longer maintain the mapping of ICD-9-CM procedure codes to Day Procedure Groups.
- **Up-to-date payment method technology.** Montana Medicaid was one of the first payers in the U.S. to implement prospective payment principles for outpatient hospital services. Since 1994, however, the Medicare program has invested millions of dollars in development of prospective payment methods that DPHHS and other payers are free to take advantage of.
- **Alignment with Medicare.** Many hospitals find it easier to submit bills and verify payment levels when DPHHS uses payment methods similar to those used by Medicare. Similar payment methods also make it easier for the Department to calculate its payment on claims where Medicare is the primary payer and DPHHS is the secondary payer.
- **Comparable pay for comparable services.** Though the Department's current payment

method embodies prospective payment principles, there are still situations (notably therapy services) where payment is made at a percentage of charges. Under the new payment method, different hospitals will be paid the same amount for the same service in almost all circumstances.

Affected providers. All outpatient services provided by hospitals and residential treatment centers (i.e., partial hospitalization) are within the scope of the project. Services provided by hospitals using non-hospital provider numbers—such as for ambulance services and dialysis clinics—are unaffected.

Out-of-state hospitals. The new payment method applies to all hospitals outside Montana, including both those in the “border hospital” peer group and those in the “out of state” group.

Affected clients. All clients enrolled in Medicaid or the Mental Health Services Plan (MHSP).

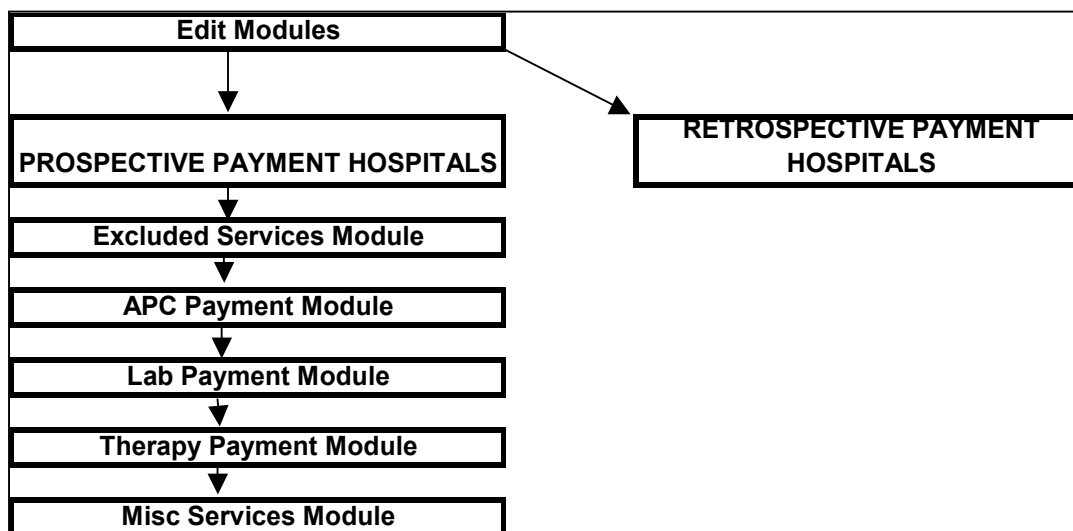
Covered services. No changes are being made to the list of services covered by DPHHS.

Prior authorization. Out-of-state facility claims will no longer require prior authorization.

Professional services. Physician services and services of other professionals currently paid separately are outside the scope of the new payment method. The only exceptions are certified registered nurse anesthetist services, discussed below.

DPHHS policy prevails. Though the new payment method is based on payment methods used by the Medicare program, differences will occur because of differences in policy, timing and other factors. In case of disagreement between Medicare and DPHHS policy, DPHHS policy prevails.

Overview of the new payment method. The following flow chart shows the new payment method in simplified form. Claims from hospitals paid using retrospective (cost-based) principles are handled separately. All other claims are paid using what is essentially a line-item fee schedule. A few services are excluded from the fee schedule based on revenue code; all other services are paid based on the line-level procedure code. Lines without procedure codes draw no payment.



II. Retrospective Payment Hospitals

Retrospective payment. Critical access hospitals in Montana as well as hospitals in isolated and rural areas of Montana will continue to be paid using retrospective cost-based payment principles. These hospitals are in peer groups 4 and 7. (See attachment for list of hospitals by peer group.) For these facilities, all services, including lab and radiology, will be paid on an interim basis at a hospital-specific percent of charges set by the Department. Final payments will be made later on through the cost settlement process.

Emergency room services. Retrospective payment hospitals will not be affected by the change in coverage of emergencies discussed below, with the exception that PASSPORT approval will no longer be needed for Emergency Room services. Therefore, the remainder of this document applies to prospective payment hospitals only.

III. Coding, Billing and Edits

Hospital billing practices. One of the goals of the project is to require as few changes as possible to hospital billing practices. Changes are as follows; hospitals should check Montana Medicaid *Claim Jumper* newsletter for information on possible additional changes.

Line-item date of service. Effective April 1, 2003, hospitals are required to specify dates of service at the line level. See the Department's provider notice dated February 3, 2003 (available on the Department's provider relations website, www.mtmedicaid.org).

Services on same day. Hospitals will be required to submit a single claim for all services provided to the same client on the same day.

Discontinuation of existing bundling policy. Under the current DPG-based payment method, hospitals must bill services provided the day before a surgical procedure on the same claim as the services provided on the day of surgery. When the new APC-based payment method is introduced, this requirement will be discontinued.

Span bills. Hospitals will continue to be able to include services for more than one day on a single claim, so long as the date is shown on the line.

When pharmacy and supply line charges exceed \$1,000. Effective January 1, 2001, hospitals had to include HCPCS procedure codes for pharmacy and supply revenue codes if the line-item charges exceeded \$1,000. This requirement was put in place to make sure that information about expensive pharmacy and supply items was included in the dataset used to design the APC-based outpatient payment method. Since the requirement will no longer be needed, it will be rescinded effective August 1, 2003. Hospitals can choose to include HCPCS codes for these revenue codes; for some drugs and supplies, the presence of a HCPCS code may increase payment.

Greater importance of procedure codes Under the new payment method, payment calculations will depend critically on the CPT or HCPCS Level II procedure code entered at the line level. Hospitals are advised to take extra care to ensure the accuracy of procedure codes, accompanying units, and the appropriateness of the procedure code for the revenue code.

Outpatient Code Editor. DPHHS will implement the Outpatient Code Editor used by Medicare and adopt some—but not all—of the OCE edits.

Remittance advices. The current HIPAA standards for the X12 835 remittance advice transaction do not allow payers to insert information into the RA about which lines grouped to which APCs. It is possible that X12 standards will change in the future to allow this.

Line denials and claim denials. If an edit causes a line on a claim to deny, the whole claim will not necessarily be denied. When a line denies for a reason that the hospital can correct, the hospital should submit an adjustment form to ACS. The claims processing system will then reprice the entire claim and adjust payment to the hospital as appropriate. (This adjustment process will be the same as what is now in place for hospital claims.)

Local codes. One of the most visible impacts of HIPAA is the prohibition of state-specific or payer-specific local codes. DPHHS, however, has rarely required hospitals to use local codes except for partial hospitalization. Changes will be made as necessary to remove all use of local codes by October 16, 2003.

IV. PASSPORT Primary Care Case Management Program

Change to policy. There is one change being considered to PASSPORT program policy as embodied in the Administrative Rules of Montana. That change is described below in the discussion of PASSPORT edits for emergency room services.

PASSPORT edits for emergency room services. PASSPORT approval will no longer be needed for emergency room services. The new payment method will implement a revised policy on emergency room services; see Section V.

V. Emergency Room Services

Applicability. The new policy applies to prospective hospitals only, including both in-state and out-of-state hospitals. It applies to all clients, regardless of whether the client is enrolled in PASSPORT.

Payment for emergency visits. If a claim for a visit includes at least one line with an emergency room revenue code (e.g., 450-459) then payment for the visit will depend on whether it meets the definition of an emergency. If it does, then payment will be made in full. If it does not, then:

- The first ER revenue code will be paid at a screening and evaluation fee.
- All other ER revenue code (45X) lines on the claim are paid at zero.
- Diagnostic services necessary to assess the patient's condition (e.g., lab, imaging, other diagnostic services) will be paid as they otherwise would have been.
- All other services on the claim (e.g., drugs, IV therapy) will be paid at zero.

Definition of an emergency. A visit is defined as an emergency if it meets either of the following criteria.

- Any line on the claim includes a Level 4 or 5 emergency department visit (99284 or 99285).
- Diagnosis is on a list of emergency diagnoses maintained by the Department. For purposes of this criterion, the claims processing system will check the admitting diagnosis, primary diagnosis and secondary diagnosis. The emergency diagnosis list will be available in the outpatient hospital manual on the Department's provider relations website.

Appeals. If a visit does not meet the definition of an emergency described above, hospitals will be able to appeal to the Department's hospital program officer. The appeal should clearly describe why the visit was, in fact, an emergency.

Cost-sharing. Under current policy, hospitals need not collect cost-sharing payments from clients in cases of emergency. The claims-processing system will check whether the claims meets the definition of an emergency given above. Hospitals need not enter an "E" in field 78 of

the UB-92 form to waive cost-sharing. (They should, however, continue to enter a “P” for pregnant clients so that their cost-sharing may be waived.)

VI. Budget Impact and Payment Calculations

Overview. The new payment method largely takes a fee schedule approach. With few exceptions, the payment depends solely on the procedure code and the units entered on each line.

Charge cap. At the claim level, payment will be the lower of the provider’s charge and the payment as calculated using prospective payment. There will be no charge cap at the line level; that is, payment at the line level may exceed the line-level charge.

Budget calculations. The current budget simulations use a conversion factor of \$47.75 which is the highest of the Medicare rates for Montana. Using this conversion factor, simulated payments are approximately budget neutral overall. Simulated payments for prospective hospitals are 5% less than budget neutral. These budget simulations use actual claims from the first quarter of 2003.

Statewide rates. The same rates will be paid to all providers within the scope of the project, with the exception of services paid by report and the minor differential in lab fees discussed below.

Services paid by report. Some services are paid by report, that is, at a percentage of the hospital’s charge for that service. The percentage will be the hospital-specific cost-to-charge ratio, so that payment approximates the hospital’s cost. This charge ratio is set by DPHHS based on Medicaid cost reports submitted by hospitals. For out-of-state hospitals and other hospitals for which DPHHS does not have a cost-to-charge ratio on file, the default percentage is currently set at 50%. For affected services, payment by report will be considered final; that is, there will be no cost settlement process for these services.

Transition period. There will be no transition period.

VII. Status Indicator Codes

Use of status indicator codes. In order to understand the tables accompanying this report it is helpful to understand the use of the line-level status indicator codes that explain how payment was calculated at the line. The code-set used by DPHHS is based on the code-set used by Medicare but with several additions. See the following table, which shows the status indicator codes in the approximate order that they are discussed in the remainder of this document.

| Status Indicator Codes Used by DPHHS | | | |
|--------------------------------------|---|----------|--|
| Code | Description | Origin | Comments |
| W | Excluded service | DPHHS | Indicates service in a prospective payment hospital that is excluded from the APC-based prospective payment method (i.e., CRNA). |
| Z | Local codes | DPHHS | Indicates partial hospitalization service billed using local code. |
| G | Drug/biological under trans. pass-through | Medicare | |
| H | Device under trans. pass-through | Medicare | |
| J | New drug/biological under trans. pass-through | Medicare | |
| N | Incidental services (bundled) | Medicare | Includes anesthesia, recovery room, most supplies, some drugs, some supplies, some observation |
| T | Surgical services | Medicare | |
| C | Inpatient services | Medicare | |
| K | Non-pass-through drugs and biologicals | Medicare | |
| S | Significant procedures | Medicare | |
| X | Ancillary service | Medicare | |
| V | Medical visit | Medicare | |
| B | Services not paid under OPPS | Medicare | |
| P | Partial hospitalization | Medicare | |
| Q | Clinical lab | DPHHS | |
| Y | Therapy | DPHHS | Indicates therapy service priced using RBRVS fee schedule |
| M | Misc codes | DPHHS | |

VIII. Excluded Services

Air ambulance (revenue codes 545 and 546). In some circumstances (high-risk maternity and neonates) hospitals currently bill for air ambulance services on an institutional claim form (e.g., UB-92) and are paid at a hospital-specific percent of charges. The Department intends to change this practice as of August 1, 2003 so that these services are billed like other ambulance services, that is, on a professional claim form (e.g., CMS 1500).

Certified registered nurse anesthetist (revenue code 964). CRNA services will continue to be paid a hospital-specific percent of charges. Note: CRNA services are the only professional services that will be paid from the institutional claim form. Hospitals bill for other professional services (when covered) on the CMS-1500 form. These services have status indicator W.

Partial hospitalization. The current payment method for partial hospitalization services will be continued, using new HIPAA compliant codes. One consequence of HIPAA is that DPHHS and other payers will no longer be able to use local codes after October 16, 2003. Hospitals and residential treatment centers will bill for these services using revenue code 912 (partial hospitalization) and HCPCS code H0035. For service levels other than sub-acute, half day, providers will use one of three Montana-specific local modifiers listed in the following table. The payment is bundled; that is, it covers all services associated with treatment that day except for psychiatrist and psychologist services that are billed separately on a CMS-1500 form.

| Current Payment Rates for Partial Hospitalization | | | |
|---|----------|--|--------------|
| Code | Modifier | Service Level | Payment Rate |
| H0035 | | Partial hospitalization, sub-acute, half day | \$71.99 |
| H0035 | U6 | Partial hospitalization, sub-acute, full day | \$95.38 |
| H0035 | U7 | Partial hospitalization, acute, half day | \$113.34 |
| H0035 | U8 | Partial hospitalization, acute, full day | \$151.12 |

There are some services where the APC grouper assigns status indicator P, Partial Hospitalization. These claims meet Medicare's definition of Partial Hospitalization, which differs from Montana Medicaid's definition. Therefore, Medicaid services that are assigned status indicator P by the grouper will not be assigned to the Partial Hospitalization APC (APC 0033). Rather, they will be priced in the MMIS according to the procedure code on the service line. The CPT codes in question are in the range of 90801 to 90857. The pricing for these services will be commensurate with the APC normally associated with each procedure code. In 2003 these procedure codes are associated with APCs 00322, 00323, 00324 and 00325.

IX. Ambulatory Payment Classification (APC) Payment Section

Overview. The heart of the new payment method is the Ambulatory Payment Classification method developed by Medicare and adopted by DPHHS.

APC version. The new method was designed using Medicare version 3.0 released in April 2002. The payment method has since been validated using Version 4.0 released in January 2003; it will be Version 4.0 that is implemented on August 1, 2003.

Calculation of fees. In general, the APC based fee equals the specific relative weight for the APC times a conversion factor that is the same for all APCs. Exceptions to this principle are listed below.

Relative weight. DPHHS is adopting the relative weights for each APC that are used by Medicare.

Conversion factor. DPHHS will set the conversion factor itself to achieve the budget target for the entire project, and to assure that aggregate payments do not exceed the limit for hospital payments described in regulations for the Medicare upper payment limit.

Pass-through payments. Payments for certain drugs, devices and supplies have status indicator codes of G, H or J. In a few cases, these codes have APC weights; in most cases, payment will be by report.

Packaged services. Payment for some services (designated with status indicator code N) is always considered bundled into payment for other services. (The APC term for bundling is packaging.) In other cases, the service will be bundled for some visits but not for others. For example, payment for IV therapy is considered bundled within the payment for a surgical visit but not for a medical visit. Medicare developed the relative weights for surgical, medical and other types of visits so that the weights reflect the packaging rules used in the APC method.

Discounted procedures. Certain surgical procedure codes carry status indicator code T. If two or more of these procedures are performed at the same hospital on the same patient on the same day, payment for the most expensive procedure will be made at 100% of the fee and payment for all other procedures will be made at 50% of the fee.

Discontinued procedures. Occasionally, procedures are started on patients but discontinued before completion. In these cases the hospital shows modifier 73 on the claim and the claims processing system will reduce line-level payment to 50% of the fee.

“Inpatient only” procedures. Medicare has designated some procedures as “inpatient only” by assigning them status indicator C. When these procedures are performed in the outpatient hospital setting, the claim will be denied. Hospitals may appeal the denial to the Department; if payment is approved then the claim would be paid by report.

Observation services. DPHHS will follow the Medicare program in making separate payment for observation care procedure codes only if the patient has a primary diagnosis of asthma, chest pain or congestive heart failure, and has met certain other conditions. In addition, the Department will pay for observation care in cases with the potential for obstetric complications. The list of diagnoses that will be used to define a potential obstetric qualification will be taken from Diagnosis Related Groups 382 (false labor) and 383 (other antepartum diagnoses with medical complications). If an observation service does not meet the criteria for asthma, chest pain, CHF or obstetric complications then payment for observation care will be considered bundled into the payment for other services.

Imaging and other diagnostic services. These services are currently paid by fee schedule but will also be paid under the APC-based payment method as of August 1, 2003.

X. Lab Payment Section

Clinical lab fee schedule. Almost all lab services will continued to be paid based on fees from the Medicare clinical lab fee schedule. Current DPHHS payment policy for lab services not on the CLAB (for example, 80055, obstetric panel) will continue as it is now. See the discussion of miscellaneous services, below.

Sole community hospitals. Sole community hospitals will continue to be paid 2% more for almost all lab services than non-sole community hospitals.

XI. Therapy Payment Section

In a change from current practice, therapy services will be paid using the same fees that DPHHS currently pays individual practitioners such as physicians and therapists under the RBRVS fee schedule. Therapy services include physical therapy, occupational therapy and speech-language pathology (CPT codes 92507-92508 and 97001-97799). Since the RBRVS fee schedule pays therapists at 90% of the RBRVS fees, the hospital fees for therapy services will also be set at 90% of the RBRVS fees.

XII. Miscellaneous Services Payment Section

A miscellaneous services payment section will include a few procedure codes that are not covered by the APC, clinical lab or therapy payment sections. These lines will have status indicator M. The procedures are as follows:

- **Screening mammography** (76092) will be paid using the same rate as the Department pays 76092-TC under the physician program.
- **Blood draws** (G0001) will be paid using current fees.
- **Dental services** are sometimes performed in the outpatient hospital setting, for example when an operating room is used for anesthesia. For some services, the procedure code maps to an APC and payment will be made using the APC logic described above. Where the dental procedure code does not map to an APC, the hospital will be paid a fee of \$68.64 per unit. This fee is based on CY 2001 claims where the hospital billed a dental service that would not have been mapped to an APC. Average charge per unit was \$122.57. Estimated cost = 56% of \$122.57 = \$68.64. The volume of these claims is small, accounting for 0.5% of the charges for services within the scope of the new payment method. Only dental services that are covered by the Medicaid Dental Program will be covered in the outpatient setting.
- **Immunizations.** Some immunization services are paid under APCs while others are not. If an immunization service is not paid in the APC section then a fee is paid in the miscellaneous services section. The fee is the same as the RBRVS-based fee paid to

physicians. If the client is under 19 years old and the vaccine is available to providers for free under the Vaccines for Children program, then the payment to the hospital is zero. Immunization administration is considered an incidental service by the grouper, and will be bundled with other services on the claim and paid at zero.

- **Durable medical equipment, prosthetics, orthotics and supplies.** As is the current practice, DME, prosthetics, orthotics and supplies must be billed by enrolled DME providers. If a DMEPOS code appears on an outpatient hospital claim, the line will be denied.

XIII. Medicare Crossover Claims

There will be no change in how Medicare Crossover Claims are paid. Medicaid will continue to pay co-insurance and deductible amounts for dually eligible persons.

XIV. Particular Payment Situations

This section of this document explains how payment will be made for certain specific services.

- **Dialysis.** Dialysis performed on patients with end-stage renal disease (ESRD) should continue to be billed to the Department using the hospital's separate provider number as a dialysis center. These claims are unaffected by the new payment method. Dialysis performed on other patients (for drug overdoses, for example) is typically billed using CPT codes that specify the patient is not an ESRD patient. The APC mapper does not recognize the CPT codes for ESRD patients but it does recognize the codes for non-ESRD patients.
- **Transfer cases.** Sometimes a critically ill or injured patient is treated as an outpatient at a hospital without being admitted to it. For example, the patient may die in the emergency department or be transferred to another hospital. In these cases, calculation of payment for the outpatient services is unaffected. These circumstances make it more likely that the hospital might perform emergency procedures that would normally be done only on inpatients, in which case the claims processing system would deny payment for the line but the hospital could appeal the denial to the Department.
- **Outpatients admitted to the hospital.** Current policy will continue. That is, outpatient services provided on the day of admission or the day preceding admission are considered part of the inpatient stay and are not paid separately.

XV. Payment Method Updates

- **Grouper updates.** Medicare updates its APC-based payment method grouper each January. DPHHS will update its APC-based payment method either every April or every

July. The reason for the interval is to allow DPHHS to simulate the effects of the new Medicare APC grouper on Montana Medicaid claims before finalizing the conversion factor and other parameters.

- **Code updates.** The American Medical Association and the Centers for Medicare and Medicaid Services release annual updates to the CPT-4 and HCPCS Level II coding systems that are effective each January 1. As part of its annual review of these changes, DPHHS will ensure that new CPT and HCPCS II codes are assigned to the relevant APCs under the APC grouper version in use as of January 1. The AMA and, especially, CMS occasionally also add and delete codes at other times throughout the year. DPHHS will review these changes on a case by case basis to decide whether to incorporate them into the payment method. In any case, codes that change throughout the year will be incorporated into the next annual update.
- **Reference to other fee schedules.** For some services (e.g., therapy, clinical lab) the outpatient payment method looks up fee schedules used elsewhere in the claims processing system. For these services, the outpatient hospital fees will update automatically whenever the relevant fee schedules are updated. Clinical lab fees, for example, are typically updated each January 1 while therapy fees are typically updated each July 1.